Marjorie Ferguson

KIDS COUNT PROJECT

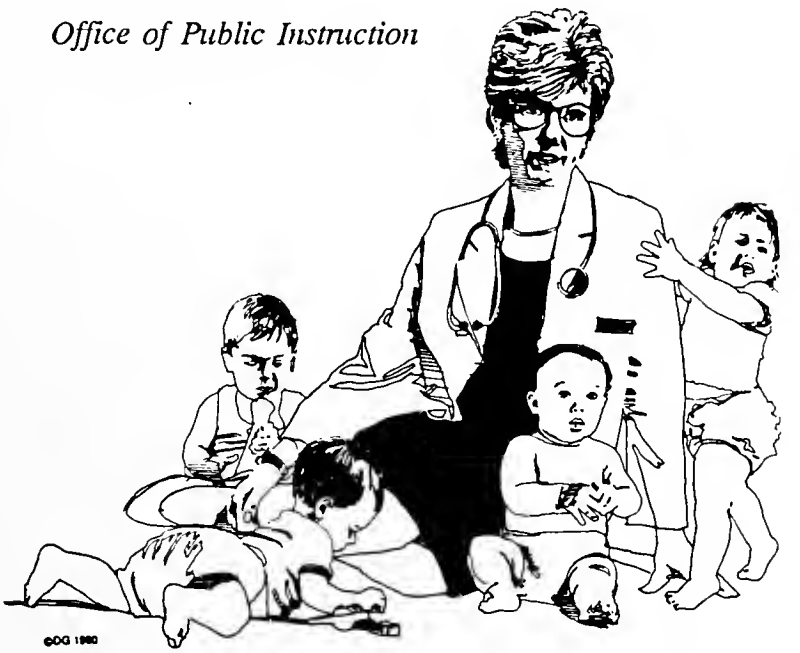
MATERNAL AND CHILD HEALTH SUBCOMMITTEE

REPORT OF RECOMMENDATIONS

Department of Social and Rehabilitation Services

Department of Health and Environmental Sciences

Office of Public Instruction



SUBMITTED To:

Governor Stan Stephens
March, 1990

KIDS COUNT PROJECT

MATERNAL AND CHILD HEALTH SUBCOMMITTEE

Report of Recommendations

March, 1990

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KIDS COUNT PROJECT

MATERNAL AND CHILD HEALTH SUBCOMMITTEE

Report of Recommendations

Background

Kids Count is an Inter-Department initiative to improve services to low income mothers and children. The Interagency Task Force was established by Governor Stephens and includes directors of the Departments of Social and Rehabilitation Services (SRS), Health and Environmental Sciences (HES), Family Services (FS), Institutions, Labor and Industry, and Office of Public Instruction (OPI). The purpose of the Task Force is to coordinate and facilitate efforts to increase efficiency, reduce duplication and promote interagency sharing of resources. The Maternal and Child Health (MCH) subcommittee is one of four subcommittees organized by the Task Force to address issues related to children's services.

The MCH Subcommittee has nine members representing three departments (SRS, DHES, and OPI). The purpose of the MCH subcommittee is to:

1. *Evaluate the current services available;*
2. *Identify major service gaps and coordination problems;*
3. *Evaluate funding sources and potential for improved allocation of resources; and*
4. *Recommend short-term and long-term solutions.*

Enhancing the health status of mothers and their children was the major focus of the subcommittee. The primary way to do this is to make prenatal care available to pregnant women to ensure healthy births and avoid more serious and costly problems down the line. In 1987, over 23 percent of Montana women did not get adequate prenatal care resulting in low birth weight, premature infants and infant death. This represents a nine percent increase since 1980. Those likeliest to get poor care were single women, minorities, Native Americans and teenagers.

Low birth weight is associated with costly medical care and high rates of chronic and disabling illnesses. A 1986 study of Medicaid costs show that over half of the $5.4 million inpatient hospital delivery expenditures were for 83 high cost infants (high cost was defined as expenditures exceeding $10,000). These babies represented only 2.7 percent of the 3,031 births covered by Medicaid during 1986. Over half the infants were low birth weight.

Prenatal care is the most cost effective means of reducing both low birth weight and infant mortality. The average cost of providing prenatal care which can prevent low birth weight is $400 compared to the lifetime costs of caring for a low birth weight baby which can reach $400,000 or more. An Institute of Medicine study concluded that for every $1 spent for prenatal care for high-risk women, $3.38 would be saved in the total cost of caring for low birth weight infants.

The subcommittee met four times between January 26 and February 19, 1990. The major areas identified by the subcommittee include expanded Medicaid eligibility; improved provider access; preventive child health programs; perinatal care; immunizations; nutritional care; early childhood screening; family planning; dental care; adolescent health care; infants at risk of developmental delay or those with special needs; service coordination and funding strategies. Short-term (within this biennium) and long-term (three to ten years) recommendations are presented for each of the areas.

This committee was established to augment and not duplicate the coordination efforts of existing groups such as the MIAMI Advisory Council. A copy of the report of recommendations was provided to interested provider groups and individuals outside state government. (See Attachment A)

The Committee prepared a summary of the maternal and child health services that are currently available in the state. In the interest of the conciseness of its report, the Committee has not included this information in the report. Anyone interested in the service inventory can contact any Committee member to obtain copies. An example of a program inventory is included as Attachment B.

EXPANDED MEDICAID ELIGIBILITY

Lack of financial access to care is one of the most critical problems facing this group. Montana has expanded Medicaid to meet federal mandates but should take advantage of additional options Congress has given that will expand coverage even further.

SHORT-TERM RECOMMENDATIONS

1. *Expand Medicaid eligibility coverage for pregnant women and children up to age six to 133 percent of the federal poverty level.*

   Responsible Office: SRS - Family Assistance Division

   Implementation Date: April 1, 1990

5/4 done

2. *Implement presumptive eligibility. This would allow qualified providers to certify temporary Medicaid eligibility for pregnant women based on preliminary income data while a formal Medicaid application is being reviewed.*

   Responsible Office: SRS - Family Assistance Division

   Implementation Date: July 1, 1990

3. *Implement continuous eligibility. This would allow eligibility for a pregnant woman to be effective from the date initial eligibility is established until 60 days after pregnancy ends.*

   Responsible Office: SRS - Family Assistance Division

   Implementation Date: July 1, 1990

4. *Provide training for eligibility staff to expedite handling of applications for pregnant women. Establish a new budget worksheet for pregnant women only.*

   5/4 done

   Responsible Office: SRS - Family Assistance Division

   Implementation Date: April 1, 1990

5/4 preliminary study from counties

5. *Study the feasibility of outstationing eligibility staff at locations other than welfare offices, such as hospitals and other health clinics.*

Responsible Office: SRS - Family Assistance Division

Implementation Date: July 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Expand Medicaid eligibility coverage for pregnant women and children up to age six to 185 percent of the federal poverty level.*

Responsible Office: SRS - Family Assistance Division

Implementation Date: July 1, 1991

ACCESS TO PROVIDERS

Expanding Medicaid to increase client participation may never achieve the goal of improved maternal and child health care unless steps are taken to ensure access to obstetrical providers. Medicaid participation among OB-GYNs has been low compared with other physicians. In addition to low participation rates, the number of doctors delivering babies in Montana is declining. From 1986 to 1988, the number of obstetrical doctors declined from 160 to 124, a drop of 29 percent. In January 1988, 18 of Montana's 56 counties were without obstetrical services with another 19 counties anticipating losing obstetrical services "soon". (Source: Montana Academy of Family Physicians). In 1987, 28 percent of Montana births were Medicaid eligible. With the recent expansions to Medicaid coverage, the percentage of Medicaid babies is expected to increase to 40 percent of all births in 1990. Low reimbursement rates, administrative paperwork and the high cost of malpractice insurance are the primary reasons cited by doctors for refusing to participate in the Medicaid Program. Other ways to improve access to care include improving outreach and education efforts.

5/4 2% increase 7-1-90 - about 54% of billed charges

SHORT-TERM RECOMMENDATIONS

1. *Increase Medicaid reimbursement for delivery services. Currently the average Medicaid payment for routine delivery by an OB-GYN is only 50 percent of usual and customary charges. The 1989 Legislature allocated $200,000 to increase the availability of delivery services in rural areas. The Medicaid Services Division has promulgated administrative rules to use this allocation to increase global fees for a normal delivery from $675.45 to $741.11 and for a cesarean delivery from $759.97 to $790.27 in FY 90-91. More significant increases are addressed in long-term recommendations since they require legislative appropriations in FY 92-93.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: April 1, 1990

2. *Reimburse rural health clinics and federally-qualified health center services for ambulatory services. These will most likely include prenatal visits, well baby visits, immunizations and other such preventive health services. This will expand the provider base for hard to reach clientele such as migrant families and urban Indians who may be reluctant to use the private medical office or public health services.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: September 1, 1990

3. *Increase participation of alternative providers such as certified nurse-midwives and nurse practitioners. These providers are currently eligible to enroll in the Medicaid Program but their participation rates are low because of fees and state licensure laws. Identification of geographic areas with low rates and participation problems should be addressed. The Medicaid Services Division is reviewing current rules that limit reimbursement for nurse specialists to 80 percent of the fee paid to physicians for the same service.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: September 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Increase reimbursement for delivery services to 90 percent of the average customary charge for the service. This would increase the global fee for a normal delivery to $1,235. This level of increase should be sufficient to meet the federal requirement that services must be available to Medicaid clients to at least the extent they are available to the general population.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: 7/1/91

2. *Implement a targeted case management system for women who are identified by assessment to be at high risk of not delivering a full-term baby. The Medicaid program could reimburse eligible contract providers for case management services. Potential providers of case management services would be DHES low birth weight clinics; migrant health clinics; urban Indian Health (IHS) clinics and IHS clinics for special needs population.*

   The case management effort will be to support the medical management of the pregnant woman and ultimately to deliver a full-term infant. The risk factors include: medical, nutritional, social psychological, environmental, financial and educational problems.

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: July 1, 1991

3. *Reduce medical malpractice insurance costs. One option the legislature might consider would be to reduce medical liability insurance premiums for doctors who deliver babies. Options could include "no-fault" liability coverage for newborn birth-related injuries or establishing a state general liability fund to offset costs of premiums or cover malpractice claims against certain individuals or types of physicians. A proposal advanced by the AMA and 32 medical specialty societies*

would replace tort law with a state agency authorized to review claims, determine fault, fix awards, investigate physician performance, and discipline offenders. While recognizing this need the Subcommittee does not see state government as the responsible party to address this resolve.

Responsible Party: Health Professional Associations in conjunction with Insurance Commissioner.

Implementation Date: July 1, 1991

PERINATAL CARE

Low birth weight (defined as birth weight of 5.5 pounds or less) is a significant predictor of infant disability and death. Lack of appropriate, affordable and accessible prenatal care has been identified as a leading cause of low birth weight. Projects are currently funded in seven Montana counties: Beaverhead (Barrett Memorial Hospital and Beaverhead County Public Health Department); Cascade City-County Health Department (CCHD); Gallatin CCHD; Lewis and Clark CCHD; Missoula CCHD; Yellowstone CCHD and Ravalli (Marcus Daly Memorial Hospital). These projects have utilized a comprehensive prenatal care coordination model to aid at-risk, primarily low income women in accessing medical, educational, nutritional, social and other services needed to ensure optimal pregnancy outcome and reduce the risk for developmental disabilities.

SHORT-TERM RECOMMENDATIONS

1. *Continue to compile data related to pregnancy outcome among women served by the seven currently funded projects.*

   Responsible Office: DHES - Perinatal and WIC Programs

   Implementation Date: On-going

2. *Continue analysis of medical and psychological risks experienced by project women and their effects on pregnancy outcomes and later parenting abilities.*

   Responsible Office: DHES - Montana Perinatal and WIC Programs

   Implementation Date: On-going

LONG-TERM RECOMMENDATIONS

1. *Develop strategies for continued funding of current low birth weight (LBW) projects and expand to additional sites as part of the MIAMI Project expansion.*

   Responsible Office: DHES - Montana Perinatal and WIC Programs, SRS - Medicaid Services Division

   Implementation Date: January 1, 1991

2. *Develop a standard maternal screening intake form for use in WIC, LBW Projects and Maternal Health Clinics for consistency of data collection and service delivery.*

   Responsible Office: DHES, SRS - Medicaid Services Division

   Implementation Date: September 1, 1992

PRENATAL EDUCATION

Lack of prenatal care is one of the important maternal factors associated with low birth weight. Prenatal care which is acceptable, available, and accessible is one way to ensure healthy pregnancy outcomes. The DHES will contract with Healthy Mothers, Healthy Babies on March 1, 1990 to administer the "Baby Your Baby" campaign. This is a multimedia outreach and education campaign which stresses the importance of receiving early and continuous prenatal care and the need for healthy habits during pregnancy. One component of this project is a telephone hotline and referral mechanism.

SHORT-TERM RECOMMENDATIONS

1. *Continue education about the importance of the "Baby Your Baby" project and encourage agencies to help fund a "corporate sponsorship" of this project.*

   Responsible Office: DHES - Montana Perinatal and WIC Programs

   Implementation Date: On-going

2. *Participate on the Advisory Committee to Healthy Mothers Healthy Babies for this project and assist in development of evaluation strategies.*

   Responsible Office: DHES - Montana Perinatal Program

   Implementation Date: March 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Develop materials about the importance of prenatal care and the results of the "Baby Your Baby" campaign for presentation to the 1991 Legislature and other interested groups.*

   Responsible Office: DHES - Montana Perinatal Program

   Implementation Date: January 1, 1991

2. *Work towards development of other educational strategies which enhance pregnancy outcome, including prenatal education classes.*

   Responsible Office: DHES - Montana Perinatal Program

   Implementation Date: July 1, 1991

IMMUNIZATIONS

Presently, vaccine provided to local clinics by the State Immunization Program is based upon the availability of Federal funds. Montana is the only state in the Rocky Mountain region (PHS Region VIII) which does not contribute to this vital preventive health service. The US Public Health Service is moving toward further limiting Montana's vaccine funds if the state continues ***not*** *to support this program. There are an estimated 33,000 children served by the State Immunization Program. Vaccine is distributed through 81 public clinics. Private physicians' offices are not provided vaccine through the State program at this time.*

SHORT-TERM RECOMMENDATIONS

1. *Review current status and new recommendations regarding vaccine administration schedules.*

   Responsible Office: DHES - Immunization Program

   Implementation Date: On-going

2. *Prepare budget recommendations for state general fund contributions for vaccine for the 1991 legislature.*

   Responsible Office: DHES - Immunization Program

   Implementation Date: Completed.

3. *Continue to explore alternate resources through state and county funds for purchase of vaccine to implement the two-dose MMR recommendations.*

   Responsible Office: DHES - Immunization Program, SRS - Medicaid Services Division

   Implementation Date: Ongoing

4. *Explore Medicaid reimbursement for immunizations to EPSDT eligible children.*

done *Responsible Office: DHES - Immunization Program, SRS - Medicaid Services Division*

Implementation Date: December, 1990

NUTRITIONAL CARE

The Special Supplemental Food Program for Women, Infants and Children (WIC) serves women and children up to age five who are both low income and nutritionally at risk. The WIC Program provides them with much needed food assistance and nutrition education. Prevention of low birth weight is a goal of WIC. The nutritional/health risks and behaviors that threaten a healthy pregnancy and baby are targeted for education, counseling, intervention, and/or referral. Congress, acknowledging WIC as an access to care, has mandated additional responsibilities: breast-feeding promotion, drug prevention education, coordination with Medicaid and MCH, and cost containment. But the need for preconceptual education for all potential parents is well recognized because diet and health behaviors before pregnancy can affect fertility and can influence the adequacy of nutritional support of the fetus.

SHORT-TERM RECOMMENDATIONS

1. *Improve the referral system and feedback system to increase referrals to and from health and human service agencies to WIC so that the number of eligible women being served is increased.*

   Responsible Office: DHES - WIC, SRS - Medicaid Services Division, Local Agencies

   Implementation Date: April 1, 1990

2. *Continue to promote breast feeding as the cost and health efficient feeding method. Promote breast feeding support by providing education and training in each of the five health planning regions. A requirement of the training session will be the establishment of a local support system for the breast feeding woman. Linkage with*

5/4 additional funds recd to accomplish this. by 9-30-90

the local hospital and clinics and WIC will be accomplished with consistency and validity being the key elements in the program.

Responsible Office: DHES - WIC

Implementation Date: July, 1990

LONG-TERM RECOMMENDATIONS

1. *Study feasibility of maximizing Medicaid reimbursement of nutritional services under the WIC Program.*

5/4 infant formula if prescribed by MD, licensed, registered nutritionist, looking at special supplemental foods.

Responsible Office: DHES - WIC, SRS - Medicaid Services Division

Implementation Date: January, 1991

2. *Regionalize local WIC programs as part of regionalization of all public health services.*

Responsible Office: DHES - WIC

Implementation Date: December, 1995

3. *Develop and establish a viable nutrition component in the health K-12 project which educates the potential parents not only in basic nutrition but also the importance of nurturing and establishing a positive feeding relationship.*

Responsible Office: DHES - WIC and MCH, OPI, CCFP

Implementation Date: December, 1993

EARLY CHILDHOOD SCREENING

States are required to offer Early and Periodic Screening, Diagnostics and Treatment (EPSDT) services to all Medicaid eligible children under age 21. The purpose of EPSDT along with Title V and other child health programs is to identify poor children's health problems as early as possible and provide them with comprehensive preventive and remedial care. EPSDT includes as a minimum the following services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and laboratory tests; dental screening furnished by direct referrals to dentists, beginning at age 3; and treatment for vision, hearing, and dental services found necessary by a screening or dental exam. These services must be provided to children under EPSDT even if they are not available to other Medicaid beneficiaries under the state's plan. The EPSDT Program is currently serving only 34 percent of the eligible population and efforts must be directed toward increasing the number of children served. Changes in OBRA 1989 constitute the most significant improvements since the program was enacted in 1967.

SHORT-TERM RECOMMENDATIONS

1. *Adopt continuing care provider option for all EPSDT children. This option provides medical case management services for EPSDT children through primary physicians.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: October 1, 1990

2. *Increase utilization of EPSDT and ensure its availability to all eligible children.*

   Responsible Office: SRS - Medicaid Services Division

   Implementation Date: July 1, 1991

5/4 99 trained to date, ongoing. NSTEP-P slots reserved @ UW

3. *Continue teaching child health assessment concepts through NCAST (Nursing Child Assessment Satellite Training) and other workshop activities conducted for local public health and other professionals.*

Responsible Office: DHES - Health Services Division

Implementation Date: On-going

5/4 Sandy's survey to provide data

4. *Explore increasing the number of well-child clinics or alternate public services for children not served by EPSDT and those who do not receive regular well child care through private physicians.*

Responsible Office: DHES - Health Services Division

Implementation Date: July 1, 1990

LONG-TERM RECOMMENDATIONS

5/4 in process

1. *Adopt the American Academy of Pediatrics Screening Schedule for the EPSDT program increasing the number of screens from 12 to 20 during the first 21 years of life.*

Responsible Office: SRS - Medicaid Services Division

Implementation Date: July 1, 1991

5/4 MCA, MNA addressing

2. *Seek funding to reestablish the functions of DHES which provided professional nursing consultation to local health departments regarding the provision of well child services.*

Responsible Office: DHES - Director's Office and Health Services Division

Implementation Date: July 1, 1991

FAMILY PLANNING

The best way to prevent many childhood problems is to make sure children are wanted. Family Planning is a preventive health measure which positively impacts the health and well-being of men, women and children. Effective family planning programs are an essential health care delivery intervention that correlates decreased high risk pregnancy and maternal and infant mortality and morbidity. The health of women and children are also improved through detection and prevention of cancer and sexually transmitted diseases with women.

Making family planning services available to all women has been identified as a priority area to reduce the rate of infant mortality, which also applies to low birth weight.

Family planning services and education help prevent unintended pregnancy in high risk women, allow women to make choices regarding the spacing and number of their children, and increase the interval between births. An interval of less than six months between ending one pregnancy and starting another is associated with a sharply elevated rate of low birth weight. Teens and unmarried women experience higher rates of low birth weight and also report higher rates of unintended pregnancies.

A recent study from the Alan Guttmacher Institute shows that for every government dollar spent on family services, from $2.90 to $6.20 (an average of $4.40) is saved as a result of averting [short-term] expenditures on medical services, welfare and nutritional services.

Unplanned pregnancies continue to wage a heavy emotional and economic toll on individuals in Montana, especially those least able to deal with this stressful situation - poverty level families and teenagers. In Montana in 1988, there were 1,818 pregnancies to teens. Of these pregnancies, 36 percent resulted in abortions; 44 percent resulted in out-of-wedlock births. One in four teen mothers will get pregnant again within 18 months. According to the State Family Planning Program, there are currently 14,000 women in Montana at risk for unintended pregnancies who are not receiving services.

SHORT-TERM RECOMMENDATIONS

1. *Increase coordination and follow-up of clients in all Low Birth Weight Prevention Projects (presently 7 sites) with local Family Planning clinics or services as appropriate. Target teen mothers.*

5/4 in process; 4/90 mtg

Responsible Office: DHES - Family Planning and Montana Perinatal Program

Implementation Date: April, 1990

2. *Review Medicaid's current contract with the Title X Family Planning Clinics to determine if there are additional services that could be reimbursed. Medicaid's federal matching rate for family planning services is 90 percent.*

5/4 process, training planned

Responsible Office: SRS - Medicaid Services Division, DHES - Family Planning

Implementation Date: July 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Increase the number of certified nurse practitioners available for placement in Title X Family Planning Clinics.*

5/4 Task Force

Responsible Office: DHES - Family Planning Program, State Task Force for Clinician Shortage in Title X Programs, and Montana AHEC

Implementation Date: September, 1991

2. *A public health education specialist be hired to enhance public awareness, outreach, and marketing efforts regarding the benefits of family planning and to identify areas for expansion of services.*

5/4 consideration by MCA, federal mandate, not in DHES budget

Responsible Office: DHES - Family Planning Program, State Legislature

Implementation Date: July, 1991

3. *Because the data indicates a substantial unmet need in Montana, additional funding and strategies to expand family planning services should be developed.*

5/4 consideration by MCA, DHES included GF $ from last session.

Responsible Office: DHES - Family Planning, State Legislature

Implementation Date: On-going

PREVENTIVE DENTAL CARE

Dental caries and periodontal disease are the two most common oral diseases of children. Both are largely preventable. Fluoridation and the application of sealants to emerging teeth in children have proven to be effective in both preventing dental disease and saving hundreds of thousands of dollars. There are only 35 Montana schools participating in a fluoride rinse program. Dental screening occurs in fewer than one half of the State's school systems.

SHORT-TERM RECOMMENDATIONS

1. *Develop strategies for increased funding, maximizing available Medicaid coverage, including EPSDT.*

ongoing

Responsible Office: SRS - Medicaid Services Division

Implementation Date: July 1, 1990

2. *Expand Medicaid coverage to include dental sealants as a preventive dental service.*

Responsible Office: SRS - Medicaid Services Division

rules proposed for sealants & orthodontia

Implementation Date: July 1, 1990

LONG-TERM RECOMMENDATIONS

5/4 exploring ways to utilize Medicare

1. *Increase funding to Dental Health Program to support the fluoride swish program in at least 50 schools, up from the present 35 schools.*

   Responsible Office: DHES - Dental Program

   Implementation Date: July, 1991

2. *Increase number of dental health screenings coordinated through public health departments and school nursing services both for pre-schoolers and school-aged children.*

   Responsible Office: DHES - Dental Program

   Implementation Date: July, 1991

3. *With increased funding, target private schools, home school children, Head Start, and licensed nonprofit day care facilities, as well as public school children.*

   Responsible Office: DHES - Dental Program

   Implementation Date: July, 1991

ADOLESCENT HEALTH

Many teens do not seek out health care except when acutely ill or injured. Yet we know that this age group is at risk for unplanned pregnancies, sexually transmitted diseases, alcohol and drug use and abuse, sexual abuse, cigarette smoking, dropping out of school, suicide, and other risky activities. In 1987, over 10 percent of Montana's births were to teenage mothers. Teenagers experience higher rates of low birth weight. Education is a critical factor in reducing teen pregnancies.

SHORT-TERM RECOMMENDATIONS

1. *Encourage adoption of Project Excellence's recommended comprehensive school health curriculum standards.*

   Responsible Office: OPI, DHES - Health Services Division, State Board of Public Education

   Implementation Date: September, 1990

2. *Maximize use of local family planning services through: improved referral systems with other community agencies, increased public awareness activities about family planning services (brochure), increased Medicaid coverage for all possible services. Target community outreach to middle and high schools.*

   Responsible Office: DHES - Family Planning, OPI, SRS - Medicaid Services Division

   ongoing, brochure being developed

   Implementation Date: September, 1990

3. *Conduct feasibility study on piloting school-based clinics.*

   5/4 subcommittee to study

   Responsible Office: DHES, OPI, SRS - Medicaid Services Division

   Implementation Date: August, 1990

4. *Develop life-options programs through school and private sector partnerships in local communities. School-based curriculums for career development and avocation development would be designed. In addition, community service placements for students would be created and job training/exploration placements developed locally.*

   Responsible Office: OPI, Labor, Private sector commerce

   Implementation Date: September, 1990

LONG-TERM RECOMMENDATIONS

1. *Pilot two school-based clinics in state with one being on a reservation school.*

   Responsible Office: DHES, OPI, Indian Health Service

   Implementation Date: January, 1992

INFANTS "AT RISK" OF DEVELOPMENTAL DELAY OR WITH SPECIAL NEEDS

Early intervention services are designed to encourage normal developmental patterns, prevent diagnosed conditions from becoming more disabling and improve the overall functioning of young children who have developmental delays or who are at risk of becoming disabled. While early intervention can often prevent or ameliorate severe disability, not all infants and young children who could benefit from such services receive the full range of services they require.

A new federal program, when fully implemented, will give children, birth to 36 months, who meet state-established eligibility criteria the right to appropriate early intervention and family support services. Montana is currently in its third year of participation in this federal grant program.

Part H of Public Law 99-457, enacted in 1986, added to the Education of the Handicapped Act a program to encourage states to establish comprehensive, multidisciplinary systems of early intervention services.

Part H recognized four urgent and substantial needs: (1) to enhance the development of infants and toddlers with handicaps and minimize their potential for developmental delay; (2) to reduce the need for special education and related services after these infants and toddlers reach school age; (3) to maximize the likelihood that individuals with handicaps ultimately will lead productive lives in the community; and (4) to enhance the capacity of families to meet the needs of infants and toddlers who have handicaps.

To meet these needs, Congress established Part H to provide financial assistance to states:

- *to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with handicaps and their families;*

- *to facilitate the coordination of payment for early intervention services from federal, state, local and private sources (including public and private insurance coverage); and*

- *to enhance state's capacity to provide quality early intervention services and expand and improve existing services.*

Part H allows participating states five years to set up comprehensive, statewide early intervention programs. Montana's system must be fully implemented at the beginning of the fifth year (October 1991) in order to qualify for continued federal funding.

SHORT-TERM RECOMMENDATIONS

1. *Increase public awareness and child-find activities throughout the state.*

   The Part H infant and toddler program, requires participating states to inform the public about the statewide early intervention program and the child-find system, including how to make referrals and how to gain access to evaluation and services. The child-find system should set up an effective method for hospitals, physicians, parents, day care programs and other providers to refer children to the early intervention system for evaluation and assessment.

   To ensure a true interagency approach to child-find activities, the system must provide for coordination among the state's special education child-find program, the Maternal and Child Health program, Medicaid's Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, state developmental disabilities programs and Head Start.

   Responsible Office: SRS- Developmental Disabilities Division

   Implementation Date: July 1, 1990

2. *Demonstrate increased interagency cooperation through the development of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.*

   Special emphasis should be placed on the development of coordinated strategies to locate children with disabilities or at risk of becoming disabled as soon after birth as possible.

   Information gathered through the Department of Health and Environmental Sciences' Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Project and the "Baby Your Baby" public education project should be utilized as a basis for development of a risk registry. Other agencies would need to cooperate with this effort and enter into agreements that would allow for sharing information while at the same time protecting the confidentiality rights of Montana's citizens. Specific tracking and follow along procedures could be developed utilizing the public health system already in place in the counties throughout the state.

   5/4 Interest, informal discussion needed Cost estimate ? Coordination ? DD possible, perhaps ? financial support, technical assistance.

   <u>Responsible Office</u>: *DHES - Health Services Division*

   <u>Implementation Date:</u> *July 1, 1991*

3. *Enter into formal interagency agreements with other state-level agencies involved in the state's early intervention program.*

   Each agreement should define the financial responsibility of the agency for paying for early intervention services, include procedures for resolving intra- and interagency disputes and any additional components necessary to ensure effective cooperation and coordination among all agencies involved in the state's early intervention program.

   <u>Responsible Office</u>: *SRS - Developmental Disabilities Division*

   <u>Implementation Date</u>: *July 1, 1990*

4. *Adopt discretionary funds option under EPSDT for children at risk or with special needs to exceed current service limitations based on medical need.*

   Responsible Office: SRS - Medicaid Services Division

achieved

   Implementation Date: October 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Make the policy commitment required by PL 99-457 to implement a statewide, comprehensive, coordinated, interagency, multidisciplinary system of early intervention services for infants and toddlers with handicaps and their families.*

   In order to continue to receive federal Part H early intervention grant funds and maintain services to approximately 100 Montana families using Part H dollars, the State of Montana must make a policy commitment to fully implement Part H and provide the full menu of services called for by the federal legislation. Such a commitment will require a further appropriation of state funds in FY 92-93 as well as improved utilization of existing federal, state and local resources.

   A conservative definition of "developmental delay" such as the one tentatively adopted by DDD to determine eligibility for Part H services would make approximately 1.5 percent of the Montana children under the age of three years of age eligible to be served. Currently 210 children under 36 months of age receive some, but not all of the required services. The proposal to fully implement Part H will provide the level of early intervention and family support services required by Part H to children currently in the program as well as those eligible children yet to be located, evaluated and served. The projected cost to the state general fund for the full implementation of the Part H infant and toddler program is $1,180,000 in FY 92 and $1,380,000 in Fy 93.

   Responsible Office: SRS - Developmental Disabilities Division

5/4 strong policy commitment @ Dept. level, in Gov. budget

   Implementation Date: July 1, 1991

SERVICE COORDINATION

In order to maximize availability and utilization of resources, all agencies involved in maternal and child health must coordinate service provisions. Coordinating services can avoid duplication of effort which increases costs of services and adds further stress to the child and family. Data collection efforts must be improved and plans must be developed to close gaps in the availability of services.

SHORT-TERM RECOMMENDATIONS

1. *Increase coordination between Medicaid and Special Supplemental Food Program for Women, Infants and Children (WIC). This includes a mandatory referral and follow-up of pregnant women and notification of the availability of WIC benefits. WIC staff presently are only able to serve 40 percent of those eligible because of funding limitations.*

5/4 ongoing

Responsible Office: SRS, DHES, DFS

Implementation Date: July 1, 1990

2. *Identify the informational brochures relating to maternal and child health services that currently exist and ensure that sufficient copies are made available to locations where women and children visit. This would include but not be limited to county welfare and human service offices, family planning clinics, WIC offices, high schools, hospitals, health departments, physician offices, etc.*

5/4 ongoing

Responsible Office: MCH Subcommittee

Implementation Date: July 1, 1990

3. *Prepare state and county plans for preventive maternal and child health care that includes coordinated and comprehensive services.*

Responsible Office: DHES - Health Services Division

5/4 needs assessments ongoing. prenatal care - Imo Co. Commissioners - local health depts. -

Implementation Date: July 1, 1990

5/4 formal being developed Task force with consumers, Depts, etc.

4. *Compile a flexible data profile of maternal/child health services and of women and children in Montana potentially in need of such services. The profile would be able to be easily updated each year and revised as needed.*

Responsible Office: 1) DHES and other state bureaus who now collect data. Concentrate on perinatal data.

2) Healthy Mothers/Healthy Babies - compile a children and youth profile.

Implementation Date: September, 1990

5. *Study feasibility of using mobile clinic to serve rural areas.*

5/4 ongoing - WIC requested # which were denied. need to continue to pursue

Responsible Office: SRS, DHES

Implementation Date: October 1, 1990

6. *Develop a written interagency agreement between MCH and Medicaid that provides for the maximum utilization of services available under MCH and utilize Medicaid to fund reimbursable services.*

5/4 groundwork being done

Responsible Office: DHES (MCH) SRS (Medicaid)

Implementation Date: July 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Expand role of MIAMI Advisory Group to monitor statewide activities, progress, coordination of services and accessibility to services.*

Responsible Office: DHES - Health Services Division

Implementation Date: July 1, 1992

2. *Establish a State Center for Health Statistics (SCHS) housed in DHES. The SCHS would be responsible for collection and storage of data, compiling required reports and disseminating identified data profiles on a periodic basis. The U.S. Public*

Health Service, Centers for Disease Control, would provide the standards and federal coordination and reporting requirements.

5/4 preliminary date from Sandy. will be taken to Human Services sub. committee

Responsible Office: DHES in coordination with SRS, DFS, DOI, Labor, Commerce, Justice, OPI, IHS and CDC

Implementation Date: September, 1993

FUNDING STRATEGIES

Funding is a major issue if Montana wants to expand maternal and child health services. Although prenatal care is cost effective, paying for care to new eligibles requires resources in the beginning. Maximizing federal funding, coordinating funding sources and identifying new funding sources are crucial if services are to be expanded.

SHORT-TERM RECOMMENDATIONS

1. *Prepare a report or pamphlet to inform interested individuals and groups (including the legislature) of the issues that impact funding and the delivery of services.*

5/4 Strategy for dissemination of KidsCount report

Responsible Office: MCH Subcommittee

Implementation Date: May 1, 1990

LONG-TERM RECOMMENDATIONS

1. *Review current allocation methodologies for Maternal and Child Health Block Grant monies designated to counties and recommend methods to allocate resources based on priority such as preventive and primary care to pregnant women and children and to children with special health care needs. Presently, the State Legislature determines the allocation division of the total Block Grant; i.e., how much goes to counties, handicapped children services, administration. The Legislature does not*

5/4 federal mandates - ? change in legislation

determine the method by which the county amount is allocated to each county, however. That authority lies with State DHES.

Responsible Office: DHES - Health Services Division, State Legislature

Implementation Date: July, 1991

2. *Review current funding of MCH Services to maximize use of federal funds. This recommendation includes transfer of general funds from DSRS to DHES to provide targeted case management to high risk pregnant women and children.*

ongoing

Responsible Office: DHES and SRS

Implementation Date: July 1, 1991

3. *Study use of voluntary donations to match federal funds.*

ongoing

Responsible Office: SRS - Medicaid Services Division

Implementation Date: July 1, 1991

MCHSUBC.ne

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DEPARTMENT: HEALTH AND ENVIRONMENTAL SCIENCES

MATERNAL AND CHILD SERVICES

PROGRAM NAME: Handicapped Children's Services (HCS)

TYPE OF CHILDREN SERVED: Children aged 0-18, and if treatment has begun but is not completed to age 21 are served for physically handicapping conditions such as heart, cleft palate, orthopedic conditions, neurologic conditions, etc. The handicapping conditions are rated on severity and how correctable they are. Children must be residents of the State of Montana and meet income criteria.

ESTIMATED NUMBER OF INDIVIDUALS TO BE SERVED IN FY90: An estimated 450 individuals, around 430 children and 20 women, will be served with direct payment for medical care in FY90. Over 1,000 children will be served in specialty clinics around the state.

TYPES OF SERVICES AVAILABLE: HCS provides payment (after any third party payments) for medical care for children and women who meet program eligibility requirements. Services can include evaluation and diagnosis, surgeries and related hospitalizations, genetic evaluations, medications, orthopedic and orthodontic braces, special infant formulas, and emergency medical transports for newborns, children with life threatening illnesses otherwise covered by HCS, and pregnant women. HCS provides clinics where children with suspected or determined diagnoses can be evaluated and followed by specialists. These clinics include heart, cleft palate, pediatric neurology and juvenile rheumatoid arthritis. Children may attend these clinics regardless of income. HCS also makes referrals to local public and tribal health nurses and to other services available to the children and will often work with out-of-state health care providers in locating necessary care not available in-state. HCS will assist families in the process of insurance payments when necessary.

ELIGIBILITY CRITERIA: HCS serves Montana children with physically handicapping conditions that can either be corrected or controlled from birth to age 18 or to age 21 as previously stated. Children may attend clinics regardless of income. Payment of medical services is provided to those whose gross family income after a deduction for out-of-pocket health insurance expenses does not exceed 185 percent of the poverty level determined annually by the federal government. HCS does not cover expenses covered by Medicaid. Thus, eligibility for the program is determined by the severity of the handicapping condition, gross family income, family size, and availability of alternative sources of payment.

FUNDING: HCS is funded 100 percent by the Title V Maternal and Child Health Block Grant.

FY 90 BUDGET: $836,396

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